Patience D. Stevenson, D.Min., LMFT, LPC

539 Center Street, Bethlehem, Pa 18018

CLIENT FACT SHEET

CLIENT NUMBER _____ DATE OF INTERVIEW _____

CLIENT NAME

_____

ADDRESS

_____

_____

PHONE: HOME _____

WORK _____

CELL _____

EMAIL:

_____

BIRTHDATE

_____

BIRTHPLACE

_____

OCCUPATION

_____

PLACE OF EMPLOYMENT_____

__

PHYSICIAN

_____

ADDRESS

_____

PHONE _____FAX _____

PERMISSION TO CONTACT

_____

(client signature)

DATE OF LAST PHYSICAL _____

MARITAL HISTORY _____

DATE OF CURRENT MARRIAGE _____

PLEASE TURN OVER

REFERRAL SOURCE

_____

ADDRESS

_____

PHONE

_____

PERMISSION TO CONTACT

_____

(client signature)

Have you ever been in counseling before? _____

If so, when? _____ with whom? _____

For what reason? _____

Do you have any medical conditions? _____

Are you currently taking any medications? _____

If so, please list names, and amount/frequency _____

What faith tradition/denomination were you raised in, if any? _____

Do you have any spiritual concerns at this time? _____

_____

_

What is you last year of school completed? _____

Which school(s) did you attend? _____

Who is currently residing in your household? _____

_____

_

What brings you here today? _____

_____

_

_____

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